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An unusual cause of ascites in a young patient

Genç hastada asidin nadir nedeni

To the Editor,

Eosinophilic ascites is a rare disorder. It may be associated with lymphoma, eosinophilic gastroenteritis, peritoneal dialysis, and parasites. Eosinophilic ascites is probably the most unusual and rare presentation of eosinophilic gastroenteritis, and it is generally associated with the serosal form of eosinophilic gastroenteritis. Eosinophilic gastroenteritis is an uncommon disorder characterized by tissue and peripheral blood eosinophilia in the absence of a known cause in the latter. Eosinophilic gastroenteritis presents with non-specific symptoms, including abdominal pain, nausea, and diarrhea (1-3). We report a case medically managed with budesonide for abdominal pain and eosinophilic ascites.

A 24 year-old male with a past medical history significant for abdominal distension presented with a three week history of intermittent abdominal pain. Physical examination revealed periumbilical and epigastric tenderness. Laboratory tests revealed a white blood cell count of 10,500 cells/mm^3 with 15% eosinophils (normally < 1%). Serum IgE level was 30 U/mL (normal 6-12 U/mL). A stool test for ova and parasites was negative. Erythrocyte sedimentation rate, antinuclear antibody, and anti-neutrophil cytoplasmic antibody antibodies were normal. Ultrasound examination performed at the time of admission revealed moderate ascites. Computerized tomography of the patients abdomen demonstrated thickening of the transverse colon, as well as ascites. The ascitic fluid was aspirated under ultrasound guidance and sent for cytological evaluation. Fluid analysis was remarkable with 45% eosinophils. Serum-ascites albumin gradient was <1.1 g/dL. Microbiology cultures of the ascitic fluid were negative for bacteria, mycobacteria, and fungal organisms. Esophagogastroduodenoscopy and colonoscopy with mucosal biopsies were performed. Thickened colonic mucosa and erythema were also noted, but no esophagitis, gastritis or duodenitis were noted. Following a diagnosis of eosinophilic colitis with associated eosinophilic ascites, oral treatment with 9 mg of budesonide daily was subsequently started. The patient responded very well to this therapy and was therefore discharged. Three months later, a follow-up ultrasound of the abdomen demonstrated virtually complete resolution of his intra-abdominal fluid. He stopped the treatment, and is doing well at the time this letter was composed.

Eosinophilic gastroenteritis presents with eosi-

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nophilic esophagitis, gastritis, enteritis, and colitis. Eosinophilic gastroenteritis can be classified based on the location of the eosinophilic infiltrate in the gastrointestinal wall, as well as associated symptoms. Eosinophils in eosinophilic gastroenteritis frequently infiltrate the gastrointestinal mucosa and, only rarely, the muscular or subserosal layers (4). Mucosal disease generally presents with bleeding, protein-losing enteropathy, or malabsorption. Involvement of the muscle layer may cause bowel wall thickening resulting in subsequent intestinal obstruction. The subserosal form usually presents with peritonitis and eosinophilic ascites, as in our patient. The histopathologic diagnosis of eosinophilic gastroenteritis requires the presence of greater than or equal to 25 eosinophils on microscopic examination, which was the case in the patient presented (5). Eosinophilic colitis in our patient was characterized by numerous eosinophils extending from the muscular wall of the colon to the subserosa, and even involved the serosal surface of the colon. In our case, severe eosinophilic colitis with serosal involvement was the likely cause of this patient's eosinophilic ascites.

In conclusion, clinicians should have suspicion of eosinophilic gastroenteritis when forming a differential diagnosis regarding gastrointestinal symptoms. Definite diagnosis is made by histopathological assessment. Treatment with steroids is the mainstay in the management of eosinophilic gastroenteritis. Clinical improvement is usually seen after treatment with a low dose of steroid.

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Isolated Crohn's disease of the esophagus

Özefagusta izole Crohn hastalığı

To the Editor,

Crohn's disease (CD) is a chronic inflammatory disease of unknown etiology characterized by chronic, granulomatous, segmental transmural inflammation that may occur in any part of the alimentary tract from the mouth to the anus. In the human upper digestive tract, the esophagus is the segment least commonly involved in CD (1,2). Further, almost all esophageal CD has coexisted with the disease of such sites as the ileum, rectum and colorectum, with only 12 cases in the literature having been described as isolated esophageal involvement of CD (1,3,4). Here, we report a patient with isolated esophageal CD who underwent esophagectomy for severe esophageal stricture with spontaneous perforation into the mediastinum.

A 60-year-old man was admitted to our hospital with complaints of progressive dysphagia for over two months, with sudden appearance of heartburn

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